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Vol. XI BALTIMORE, MD., APRIL 15, 1915 No. 2

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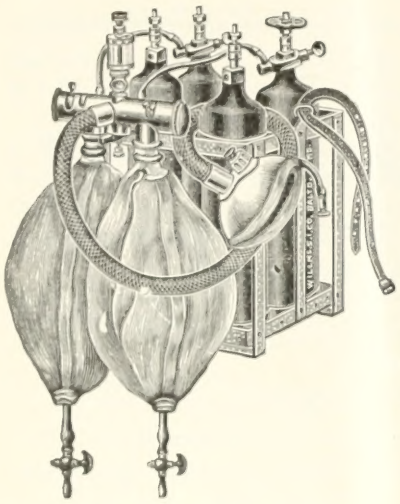

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THE HOSPITAL BULLETIN

OF THE UNIVERSITY OF MARYLAND

APRIL 15, 1915

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Vol. XI BALTIMORE, MD., APRIL 15, 1915 No. 2

ROENTGENOLOGICAL ASPECT OF INTESTINAL STASIS.*

By HOWARD E. ASHBURY, M.D.,
Baltimore, Md.,

Roentgenologist to the Hebrew Hospital and St. Joseph's Hospital; Assistant in Orthopedic Surgery to Johns Hopkins University and Dispensary.

INTRODUCTORY REMARKS.

As one of the means of diagnosing stasis in the alimentary tract the Roentgen Ray has been given the foremost place; other methods are valuable, and where simply the time for passage of the meal through the canal is desired, the administration of any bland inert material may be used, the significance being the time of appearance in the stool. This, of course, does not throw any light upon the usual surgical causes of stasis. This leads us to divide stasis into those cases which are due to simple delay without obstruction and those due to mechanical obstruction in some part of the alimentary tube. The first group suffer more from true auto-intoxication, while the second group seem to have symptoms which are due to mechanical obstruction.

WHAT IS STASIS?

Lane's definition: Such an abnormal delay in the passage of the intestinal contents through a portion or portions of the gastro-intestinal tract as results in the absorption into the circulation of a greater quantity of toxic or poisonous materials than can be treated effectually by the organs, whose function it is to correct them into products as innoxious as possible to the tissues of the body.

*Read before Baltimore Medical Society, November, 1914.

CAUSES OF STASIS.

Stasis may be caused by existing visceroptosis, intestinal kinks, adhesions and dilatation or enlargement of various portions of the alimentary tube; the result of congenital malformations, which produce a delay in intestinal prochoresis and localized infection of the mucous membrane, producing perityphlitis.

ROENTGENOLOGICAL FINDINGS IN STASIS.

Stasis, when due to mechanical obstruction, shows increase of the normal time for the passage of the opaque meal through the intestinal tract; retention at point of obstruction and at the various sphincters from below upward; dilatation on the oral side of the obstruction; displacement of portions of the neighboring hollow viscus when the cause of the obstruction is adhesive bands. The conditions producing stasis not associated with mechanical obstruction are incompetent ileo-caecal valve allowing a return influx of the caecal contents into the ileum; spasm of the ileo-caecal valve preventing contents of the ileum from passing into the caecum, and a sagging of the transverse colon causing sharp angulation of the splenic flexure; dilatation of the colon either congenital or acquired; redundancy of the pelvic colon with lengthening and atony.

OPINION IN FAVOR OF AND OPPOSED TO THE STASIS THEORY AS A CAUSE OF AUTO-INTOXICATION.

Lane stands foremost among those who attribute auto-intoxication to stasis, and who makes most of his diagnoses by the Roentgen method, and who practices the most radical surgical procedures to improve drainage. He has many followers. Jordon thinks that a sagging transverse colon by causing a sharp angulation of the splenic flexure causes stasis.

It is frequent that in these cases which have

FIG. 1—10 hours: Gastric retention and intestinal delay due to ileal kink.

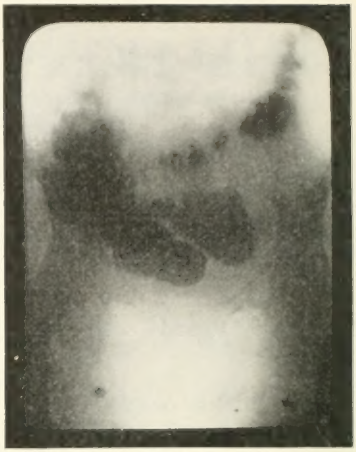

FIG. 3—12 hours: Dilated terminal ileum due to mechanical obstruction at the terminal ileum.

toxic symptoms the progress of the meal is usually normal up to the splenic flexure (Figure 5), and here it remains until moved on by some artificial means. The most likely explanation is Jordon's idea as I have frequently noted in my own work.

Einhorn gives credit to Glenard for the angulation theory of stasis and claims that Bouchard and Combe advanced the theory of stasis as a cause for auto-intoxication. Einhorn thinks that unless there is a real mechanical obstruction or a substantial organic lesion interfering with the intestinal current, that a tempory delay or stasis does not mean much and is often seen in insufficient nutrition. The unobstructive cause of stasis is constipation, which not always causes auto-intoxication, for occasionally a patient may not have any bowel movement for several days and present no abnormal symptoms.

Bassler disagrees with Lane's theory and thinks

FIG. 2—6 hours: Ileo-caecal spasm.

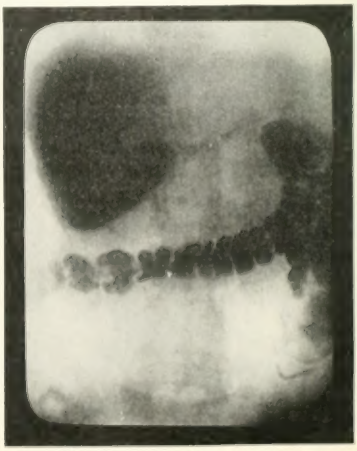

FIG. 4—18 hours: Kinked appendix, adherent, causing partial gastric delay.

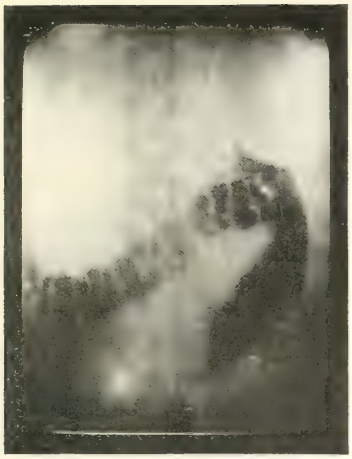

Fig. 5—50 hours: Delay at the splenic flexure, ileal stasis, angulation at the hepatic flexure

"that if one would examine bacteriologically a number of stools of these persons and compare them with normal individuals significance would be noted. The primary cause of the conditions is mostly a bacterial matter, and it is the food bacterial products that eventually bring about stasis, which surgeons are endeavoring to remove by drainage, but which cannot be done successfully because the infections commonly continue after operation." He thinks "that the Roentgen Ray method of diagnosing Intestinal Stasis, while valuable and the best we have, is liable to fallacious conclusions." The misfortune was when medical men utilized the Roentgen Ray in connection with diagnosis in the abdomen they did not engage as their first work the normal individual. He is surprised to find the number of normal individuals who present all the Roentgen Ray signs that have been held so important for this diagnosis and reiterates that we must be slow and conservative in drawing definite conclusions from Roentgen plates alone.

Fig. 6—24 hours: Perityphlitis, scybalous masses in the transverse colon, colonic stasis.

PERSONAL OBSERVATIONS IN 260 X-RAY EXAMINATIONS.

Eighty-eight instances of intestinal stasis were noted, of which 73 were ileal stasis and 16 colonic

Fig. 7—Colon enema: Redundant sigmoid, dilated colon due to congenitally long mesentery.

stasis. Sixty-six and six-tenth per cent. were explained by the existence of the following conditions: Gastroptosis and enteroptosis, 6.7%; postoperative adhesions, 6.8%; incompetent ileocaecal valve, 2.8%; chronic appendicitis, 2.5%; malignant disease of the stomach and intestines, 2.5%; gastric and duodenal ulcer, 1.8%; giant colon, 1.7%. Twenty-seven of these patients who presented stasis were unexplained and were found associated with pulmonary tuberculosis, typhoid fever, nephritis, arterio-sclerosis and neurasthenia. These unexplained cases presented more symptoms that might be attributed to auto-intoxication than the purely mechanical ones.

fluoroscopy and radiography [illegible] intestinal examination [illegible] should follow the meal from above downward, as well as by means of an [illegible] within one-half hour [illegible] Within six hours there is still a trace in the ileum, while nine hours is the time allowed for the normal [illegible] delay in the terminal ileum is the physiological contraction of the ileo-caecal valve. Pathological conditions that may cause a delay in the meal reaching the terminal ileum are bands of adhesions, tumors within or without, displacements and [illegible]

In studying emptying time of the ileum the condition of the stomach must be taken into consideration, since any delay in the evacuation of the stomach may prevent the chyme reaching the lower ileum. Ptosis of the small intestine may cause a moderate delay, but it is not an etiological factor in production of chronic constipation. Delayed entrance of the chyme into the caecum may be due to spasm (Figure 1) or incompetency of the ileo-caecal valve and adhesions [illegible] Lane's kinks (Figure [illegible]). Dilatation of the terminal ileum (Figure 3 [illegible] is evidence of obstruction and demands surgical intervention. The delay may exist from nine to [illegible] hours.

The caecum (Figure 4) and ascending colon retain the chyme for a longer period than any other portion of the large intestine, and consequently [illegible] much greater opportunity for bacterial action, and if dilated from constipation is the most [illegible] manufacturing toxines. When associated with ptosis of the hepatic flexure [illegible] (Figure 6) [illegible] Tuberculosis of this region is frequently [illegible] usually recognized as [illegible] but [illegible] typhoid [illegible] ulcerative form and dysentery. The [illegible] to loss of muscular tone, the second to anti [illegible] and the last to [illegible] the [illegible] the system. The average time for the opaque meal to [illegible] the caecum is [illegible] usually [illegible] at the [illegible] after [illegible] hours, although frequently it remains in the [illegible] [illegible] hours. This delay is termed stasis.

The same principal that applies to obstruction in the small intestine is seen here, that when the [illegible] is delayed, there is dilatation of the area [illegible] of appearance of [illegible] tions, constrictions and evidence of [illegible] the point of [illegible] We can [illegible] verify these findings by fluoroscopy, when the opaque enema is seen to stop gradually dilate the intestine on the anal side of the obstruction. In the case of simple angulation the bowel [illegible] straighten out like a kinked hose, the meal continuing its progress until it reaches the caecum. The usual time for the passage of the enema is from four to five minutes, occasionally the period may be less or greater. The former can [illegible] detected accurately by fluoroscopy accompanied [illegible] careful palpation. The latter may be determined by plates taken serially.

In cases of constipation the opaque enema is used after thorough cleansing of large bowel and the most usual appearance is dilatation with elongation (Figure 7). I am inclined to believe that these enormous colons are originally of congenital origin, the existence of long mesenteries which are seen in certain types of individuals, occurring in families. The dyschesia is apparent in a dilated rectal ampullae. This is more apparent when the opaque enema is used but by the occurrence of scybalous masses (Figure 6) when examination is made by administration of meal by mouth. The plates made by the two methods are so different in appearance that one can tell at a glance when the enema has been used. The difference in the two appearances being that haustral segmentation is more marked when the meal has been given by mouth than when the enema has been used. One quart is usually sufficient to outline the entire colon and can be administered in safety, provided the preliminary cleansing of the colon has been executed.

[illegible]

A word about the normal colonic peristalsis. It has been noted by the Roentgen study of the motor phenomena that we have a regular peristaltic movement, a greater peristaltic movement, antiperistaltic and [illegible] movements involving a whole section of the colon. The first is dependent upon the action of circular muscle fiber and [illegible] a [illegible] area and presents a [illegible] movement, the [illegible] is more [illegible] and

causes a marked displacement of feces. Antiperistalsis is known to exist normally and may account for some peculiarities often seen. The stormlike movements occur just before or during defecation and are influenced by the injestion of food, and are apparent during X-ray examination by the disappearance of segmentation and a remaining linear shadow behind the progress of the contents. As the motion subsides the segmentation reappears. These appearances are seen best following bismuth meal when studying functional disturbances, the bismuth enema being more adapted to discovering organic obstruction.

CONCLUSIONS.

The conclusions drawn from Roentgen observations should be carefully verified and modified in certain instances by recognizing the numerous idiosyncrasies of our patients, nervous phenomena being apt to lead us astray. What has been said of the changes associated with stasis may be summarized as follows: That the frequent cause of delay is obstruction, and when persistent demands conservative surgical interference. That stasis occurs frequently associated with other organic disease, and before symptoms are attributed to stasis these other conditions should be eliminated. The final disposition of the case should not rest entirely on the X-ray examination. When peculiar conditions are noted, it being wiser to use this information as confirmatory. With the standardization of Roentgen evidence, the method is becoming indispensable.

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PRACTICAL EXAMPLES OF HISTORY TAKING.

By Ernest Zueblin, M. D.

A Guide for the Undergraduate Students.

The importance of a careful method in history-taking has been duly emphasized in the pamphlet published by Prof. Gordon Wilson. The students who follow his excellent advice will be greatly aided in their work. Practical examples of histories taken by students during the past years will also be a help to the present pupils. These histories are the exact copies of the papers turned in and supplied with annotations and suggestions. They will be published at regular intervals and will contain instructive and interesting facts. In succession the infectious diseases (typhoid fever, malaria, septicemia, meningitis, tuberculosis, articular rheumatism, etc.) cardiac, pulmonary, kidney, diseases of the digestive organs, disturbance in nutrition and metabolism, disturbances of internal secretion, will be considered.

These histories are intended not only as a supplement to the didactic course in medicine, but also as a help to the method of history-writing.

It will be observed that three histories were written on the same subject. In explanation I want to say that this was done to show how the patients are likely to give different answers at different times. In this connection it may be said, if student and patient work hand in hand, *i. e.*, if the student will do the proper quizzing and the patient give the correct information, better results will be achieved.

C. K., 35 years of age, white, American, single, farmer, living in Deansville, Charles county, Md.

Complaint.—Pain in the leg[1] and general weakness.

Family History.—Father is living and well. Mother died from old age at 76; has three brothers living and well; has two sisters—one died in childbirth and the other died before the patient was born.[2]

Exposure.—One of his neighbors, with whom he was working, died of typhoid[3] one month before he was taken ill; they also took their drinking water from one well.[4]

Past History.—Had measles twice, when 14 years old[5] and when a boy five years old, and un-

and does not remember when. Had chancre 10 years ago and gonorrhea nine years ago.

Habits.—Drinks coffee three times a day, tea occasionally, rarely drinks whiskey and beer.

Present Illness.—Six months ago, [illegible] general malaise, laziness, and 10 days later was taken [illegible] in the leg[14] and general weakness.

Digestive system.—Appetite bad, [illegible] tongue,[15] bowels regular, [illegible]

Pulmonary system.—Cough, especially at night,[15] and brings up mucous sputum,[16] no pain in the [illegible]

Circulatory system.—[illegible] swelling of ankles [illegible] no ascitis, no palpitation of heart.[17]

Urinary system.—Bladder regular,[19] no pain and [illegible] passing water.

Nervous system.—Has headache; has no pain but in the leg; is irritable.[20]

Sp. Senses.—Negative.

[illegible]

(1) It is important to state which leg is affected, right or left. (2) Further, the onset and recurrence of weakness, whether observed in the morning or during the day following physical exertion, should be noted. (3) There may be pains, the character of which may be dull, shooting, etc. The presence or absence of swelling.

(4) It is always desirable to give the cause of death, whether it was as a consequence of an acute disease or a wasting disease.

In this instance the duration of the disease, the immediate cause of death should be noted.

(5) Were all [illegible] examined? Were there cases that occurred in persons having [illegible] the same water?

(6) If possible the duration and character of the [illegible] should be noted.

(7) The number of hemorrhages received, [illegible] should be noted whether [illegible] manifestations [illegible]

(8) If possible, the amount of alcoholic beverages consumed should be stated, the reason whether or why the patient became more moderate in their use. The use of tobacco by smoking or chewing should be noted, also digestive and nervous disturbances which may result from such habits.

(9) The character and site of the headaches, their duration, intermittent or continuous; the time of their appearance, day or night, should be noted.

(10) The time and duration of the symptoms should be given, whether they occurred independently [illegible]

(11) If possible, the patient should be asked how long he was able to continue his work, notwithstanding these manifestations; further, the date when he had to give up his work, when he had to go to bed; further, the measures he had taken for the alleviation of these symptoms.

It is important to mention the name and address of the doctor who attended the case, the date on which he was first called, the reasons why the patient was committed to the hospital.

(12) As already discussed under Figure 1.

(13) How was the appetite previous to patient's disease? Was anorexia present among the first morbid symptoms? If the patient previously had any gastric complaints, when and how were they treated?

(14) The first occurrence of vomiting should be noted, the character of the stomach content voided, whether it followed immediately the intake of meals or several hours afterwards. The presence or absence of pains, existence of gas, distension of abdomen, should be considered.

(15) Since when did the patient cough? What is the character of the cough (dry, hacking, moist, etc.)

(16) The amount of sputum, its physical aspect, the time of expectoration must be noted.

(17) There is no indication as to the presence or absence of temperature, night-sweats, loss in weight, etc.

(18) The symptom of dyspnea at rest or after exertion has not been considered.

(19) No mention is made of the amount of water passed, the character of the urine, presence or absence of blood, presence or absence of sediment.

(20) There is no mention made of the date of such irritability, whether it has to be consid-

ered as a direct consequence of the present illness, the nature and duration of sleep has not been mentioned, nor were the muscles, joints and bones considered.

Name, C. K.; *address*, Charles county, Md.; *age*, 35 years; *social condition*, single; *occupation*, farmer; *nationality*, American; *race*, white.

Complaint. Patient says he came in hospital for tired feeling; was unable to work and was told by his physician that he had typhoid fever.[1]

Family History.—Father living and healthy, aged 76 years. No history of tubercular malignancy, tuberculosis or insanity. Mother died at age of 76; patient does not know any cause other than old age, although he says she complained of heart trouble two or three years before her death. Mother was married twice. Patient does not know cause of first husband's death. Has one whole brother and two half-brothers, all living and healthy; ages not known. Two sisters dead; one died before patient was born and does not know the cause; other sister died from childbirth; age at death not known.[2]

Family History.—Father living and healthy, (uncomplicated). Says he had it again when he was 25 years of age (uncomplicated); lasted about 10 days;[3] also gives history of sore on penis[6] nine years ago. Had mumps at nine years and recovered O. K. Had whooping-cough when quite young (uncomplicated). Had gonorrhea nine years ago and lasted for 18 months; says he had sore on penis at same time; was treated for it and it disappeared about six month afterwards. Patient gives history of pain[20] in shoulder joint of dull, aching character and radiating down the arm; said it started five years ago and has an attack every four to five months.[21] Has been operated on twice for inguinal hernia on right side.

Habits.—Drinks tea and coffee at meals and occasionally takes whiskey and beer, but does not use either to excess.[8]

Exposure.—Hires on farm in Charles county, Md. Says that one of the workmen living on the farm died about three months ago from typhoid, and all had been drinking same water.[4]

Present Illness.—Started about 10 days before patient entered hospital. Said he was first taken with headache, which was constantly present; said he was unable to complete his day's work; would have to quit and rest; also had pains over his entire body of dull, aching character, and felt every day as if he had a chill. He was constipated at the time. These symptoms gradually became worse, so he went to see a physician and was told to go to bed, which he did. This was on Sunday night and the following Friday, which was October 24th, he entered the hospital. Says he has not been delirious at all and complains at present of pains in back.[9-12].

G. I. Tract.—Appetite poor; bowels constipated; said he only had movement every two to three days; no pain before or after eating [14].

Pulmonary Tract.—No cough,[15] no expectoration of blood, no pain in chest; has lost some weight.

Urinary.—No pain or frequency of urination.[19]

Circulatory.—No shortness of breath, no swelling of ankles or feet; no discomfort in cardiac region.[13]

Joints.—Has had frequent attacks of pain in right shoulder, which he says is rheumatism; other joints negative.[20]

Nervous.—Previous to present illness only occasional headache, but since that time he has had it almost constantly until he entered hospital; since that time it has not been present.[20]

Special Senses.—Eyes negative; ears, some ringing in the ears;[22] no pain or discharge.

In the preceding history on the same case, as in No. 1, we have a more detailed account of the patient's past and present history.

(1) We have a more satisfactory account of the patient's chief complaint. The history being taken before No. 1, no complaint existed about pains in his left leg.

(2) The family history brings more important details. With the present infection, the patient relating the heart disease of his mother, from which she died, we may suspect the possibility of a congenital weak heart of the patient, which during his present illness may favor the occurrence of undesirable circulatory disturbances.

(5) The repeated infection by [illegible] cases has received more consideration in this instance. No mention is made whether patient had any other infectious diseases.

(6) The veneral infection and its manifestations are given more in detail, although no mention is made as to the complete disappearance of these and other luetic manifestations.

(20) In this history we find an indication of rheumatism, which has not been mentioned in the previous history. The site where the pains oc-

[illegible] mentioned, considering the [illegible]

[illegible] ned.

[illegible] remarks on the same number in the preceding hist[illegible]

[illegible] In this instance we have a few mor[illegible] from the other typhoid case preceding [illegible] patient's infection. It would be desirable to ascertain whether the patient came in contact with this [illegible] whether the drinking water was also [illegible] of the patient's infection. It seems striking that the typhoid infection of the fatal [illegible] have persisted three months this patient's infection (typhoid carrier, walking typhoid).

[illegible] In this history we have a more [illegible] regard of the onset, the succession and symptoms of the patient's disease, which method can only be encouraged.

(13-14) See remarks on his previous history.

(15) The information obtained is not in accordance with the previous history so far as cough and expectoration are concerned. It may be possible that the symptoms mentioned in the first [illegible] did not exist when the second history was [illegible]

[illegible] see remarks on the same number in [illegible]

[illegible] The remarks in this history combined with those given in history No. 1 complete [illegible]

[illegible] and duration of [illegible] the [illegible] hearing, the pres[illegible]

Past History.—[illegible] when a boy and at 25. Was very sick following second attack.[illegible] Whooping cough and tonsilitis when small. Negative to pneumonia, typhoid, pleurisy, rheumatism, scarlet fever and diphtheria; malaria negative.

Venereal History.—Had gonorrhea nine years ago. Says he [illegible] breaking out on body about five years ago.

Present Illness.—Patient started to feel bad on about October 11. His principal symptoms were loss of appetite, general malaise, weakness, headache, with pains in his back and the back of his legs. These symptoms increased in severity, so that about a week later he was obliged to stop work and go to bed. He consulted a physician, who sent him to the hospital. He entered here October 24, 1913. His condition since in the hospital has improved and he feels very well now, except that he is weak and hungry.

Respiratory.—No cough, no spitting of blood, no night sweats or loss of weight up till present illness.

Cardiac Vascular.—Shortness of breath on exertion. No swelling of feet or ankles. Has occasional palpitation and pains in precordial region.

T. Intestinal.—Appetite good now. No pain, nausea and vomiting. Diarrhea.

T. Urine.—No pain, burning, urgency or frequency. Does not have to get up at night.

Joints.—Negative.

Nervous.—Does not sleep very well. Does not dream. Worries over small affairs. [illegible] Special senses, negative.

Habits.—Two cups of tea a day. Uses liquor in moderation. Chews tobacco. Uses no drugs.

C. S. B.

[illegible] It is interesting to find the [illegible] attack [illegible] of a more serious type and [illegible] tion tallies with the general impression prevailing among physicians.

[illegible] Could be more complete as [illegible] only [illegible] a [illegible] [illegible] Infection and illness [illegible] all ren[illegible] the [illegible]

[illegible] [illegible] [illegible] [

be desirable to mention the causes, the degree, duration and frequency of cardiac palpitation or precordial pains.

(20) The reason of insomnia, the duration of sleep, should be inquired into. Further, it is desirable to let the patient narrate the character of his worries, the causes, occurrence and duration of excitement, the possible existence of mental depression, etc.

(8) See criticism in first history.

The general impression of this history is good, particularly the information as to the present illness is concise.

Mrs. W. D. O'C.; *age*, 41 years; *address*, Union Bridge, Md.; *social condition*, married; *nationality*, American; *occupation*, housewife; *complaint*, aching pain on the extremities and back.[1]

Family History.—Father living and well; age, 81 years. Mother died when 72 years; cause, Bright's disease. Four brothers living and well; one boy died when 10 months old; cause, cholera infantum. Five sisters living and well; two sisters dead; cause unknown; one of them died during pregnancy. Husband living and well; age, 41 years. Had four boys, two living and well and two in the hospital with typhoid. One boy died when three months old; cause unknown; one died three weeks before she got sick; cause, typhoid fever-pneumonia.[2]

Negative to malignancy, rheumatism, tuberculosis, apoplexy, heart disease, nervous disease, whooping cough, malaria, diphtheria, measles, scarlet fever, etc.

Exposure.—Patient has been living at Union Bridge, Md., but said there was no typhoid fever around that place previous to its outbreak in her family. October 7 her daughter complained of malaise, pain in the extremities, etc.; in a few days a physician was called in and diagnosed the case as typhoid fever. The patient nursed her daughter for one week of her illness. The physician in charge said that it was from the water and ordered that all water to be used should be boiled, nevertheless the patient and two of her sons developed the disease.[4]

Past History.—Negative to rheumatism, cardiac and nervous diseases. Negative as to pneumonia, scarlet fever, whooping cough, measles, malaria, etc.; has occasionally attack of dizziness and earache, which, she states, is due to eye strain.

Present Illness.—About two weeks ago the patient was feeling badly, but did not go to bed until Friday, October 7. Previous to going to bed she complained of general malaise, chilly sensation and lassitude all over the body; later on went to bed, when she had considerable fever.[11]

Alimentary Tract.—No nausea or vomiting, appetite fair, no sense of fullness or weight in the stomach, no pain, before or after eating, in the stomach. Bowels constipated at time of admission in hospital.[13].

Pulmonary.—No cough or expectoration; dyspnea on slight exertion;[16] no spitting of blood nor pain on chest; no night-sweats; no pain on chest exertion or expiration; bleeding from nose at beginning of illness.[17]

Cardiac.—Dyspnea on slight exertion; no swelling of feet or ankles; no palpitation or pain on precordial region; no dizziness, vertigo or ringing in the ears during the present illness.[18]

G. Urinary.—No pain or blood in urine; don't have to make water at night. A discharge from vagina, she said, has been present for 20 years.

Muscular.—General feeling of soreness throughout body.[20]

Nervous.—Has had frontal headache;[21] don't radiate.

Extremities.—Negative.

Menstrual.—Negative. No clot, no pain; lasts four to six days; normal every 28 days, etc.[22]

REMARKS TO THE PRECEDING HISTORY.

(11) The location of these pains—in which part of the extremities should have been indicated.

(2) The family history has been well considered and furnishes a valuable contribution to the vitality of the patient's family.

(4) The history of exposure is rendered very well, and shows plainly the spread of the disease within the family, causing the illness of the mother and three children, and one infection ending fatally.

This shows plainly how unhygienic conditions may endanger and cause the ruin of family life for a number of weeks.

(5) The past history is well considered. It would be desirable, however, to mention the time and occurrence, the frequency of these attacks of dizziness and earache; the reason why they are attributed to eye strain; whether an examination by the oculist and change of glasses caused the disappearance of these symptoms.

(10) The prodromal symptoms should be

more fully considered as to their appearance, the time of the day, their duration, the reason why and when patient had to go to bed; also the presence or absence of perspiration, the loss in weight, presence or absence of epistaxis headache, thirst, should have been stated.

(13) The functions of the bowels previous to the onset of the illness should have been mentioned.

(16) The character of cough producing dyspnea should be considered, also the time of its first appearance.

(17) The exact time of appearance of epistaxis, the character and quantity of blood voided, the frequency, should have been considered.

(18) It would have been well to mention the cardiac symptoms as to dizziness, vertigo, ringing of ears, not only during the present illness but preceding it.

(20) Since when did the symptoms exist? Were they observed only during the present illness or did they precede?

(21) The character, appearance and frequency of the headaches should have been considered, the onset and duration, whether continuous or whether they come on by attacks. Further, the mental condition previously and at present, the amount of rest, the character of sleep, should have been mentioned.

(22) In women, it is important to mention the date of the last menstruation, as in this disease miscarriage and premature parturition have to be counted among the possible complications.

[illegible]

A careful perusal of these histories will show the advantage of a thorough investigation before the diagnosis of the disease can be made from the history alone. We see how differently the individuals react upon exposure to typhoid infection, how varied their prodromal symptoms may be, how [illegible] need not present all the [illegible] typhoid infection; they further show how the termination of the cases [illegible] different [illegible]

[illegible] Randolph Winslow is a recipe of the following letter from his uncle Dr. [illegible] Winslow, class of 1905, who is located at [illegible] Wis.

"March 15, 1911.

"Dear Father:

"It is a long time since I heard from home, and still longer since I have written, although [illegible] week I have intended to do so. I trust all are well at home as we are here. Since having my appendix removed I believe I have felt better than previously. Of news in general I am compelled to state there is none, so far as I know — [illegible] my letters are all personal narratives of the great 'I am' type. Perhaps you would be interested to know that Dr. Ochsner was instrumental in locating a little village of Swiss named Honey Creek, not very far from here, and still has a farmer brother living there. The people hereabouts speak of him as [illegible] with an absence of awe that is characteristic of this part of our dark continent. Titles are handled without gloves, or far more often entirely divorced from one. I have become quite accustomed to being addressed as Mr. Winslow. As a matter of fact, Dr. Ochsner has donated this town with a hospital site, provided the townspeople furnish the wherewithal to erect one. The building seems to be somewhere in the dim and distant future, as this place is torn by religious factions. The Catholics will not contribute to the scheme, as they would like to have a hospital run by Sisters. Recently there was a lecture by some scrubs anti-Catholic in sentiment, and indeed especially attacking the monasteries. Needless to say an enormous crowd attended. Last Sunday I attended a Christian Science lecture delivered by a Boston member, and the hall was jammed. In some respects it was a good address, [illegible] and delivery were excellent, but he stated that they had been able to cure [illegible] tuberculosis, locomotor ataxia etc. It seemed to me that the people grasped just enough of the doctrines to be harmful to them. I have often wondered whether you have ever used your Murphy button. I have had fine results with mine. [illegible] I used it on [illegible] to the splenic flexure, along with about 10 inches of ileum, and the button was passed on the eighth day. Patient was walking about and left hospital on tenth day. I saw him yesterday. His bowels were moving twice daily and he was looking fine. Also I have a case in which I did an exploratory operation and found the cause of the jaundice to be due to obstruction from a pan-

creatic induration without doubt carcinomatous in character. I anastamosed it to the transverse colon with round button. Patient is convalescing O. K. I am giving him peptonized food. Do you suppose those cases would be sufficiently interesting to write them up? I never saw the operations performed while in the hospital at home, but know that was merely a coincidence, so thought it would not be worth while.

"I received a letter quite a while ago from the secretary of the College of Surgeons stating that, owing to the number of applicants, they had not been able to investigate them all yet, but would inform me regarding the result as soon as he received word. I do not look forward with much optimism, as I know my worthy compatriots here would take great pleasure in spoiling my game. Recently a lady whose husband I was going to operate upon was stopped by one of these ethical gentlemen, who said: 'I hear your husband is going to be operated upon at the Baraboo Hospital.' 'Yes,' she responded. 'Do you want him killed,' he said. 'Why don't you take him where they know something?' 'That's what I think I am doing,' she said. I had half a notion to interview the doctor, but there is no county society meeting, so I decided to let the matter drop, as I could only have a row to no purpose. Since coming to Baraboo I have never been called in consultation or been fortunate enough to have a single case referred to me by the town physicians, but I get work in spite of them all. Well, daddy, I didn't intend to treat you to a dish of woe, but just want to let you know how the wind is blowing out here. I expect it is quite annoying to treat a case for 'too much acid in the blood' and then have some fool remove the gall bladder with a stone in it the day after you are fired from the case, so I try to be reasonable.

"We are having a little flurry of snow today. There has been snow on the ground, with sleighing almost continually since before Christmas, but during the last week there has been a thaw, so we have some hopes that spring will come some day. I suppose it is nice and mild at home now. We are anxious to plant our garden soon. Would you believe it, we have hardly bought a vegetable since last spring, because of the canned ones Flo put up, and still have parsnips and salsify in the garden awaiting until the ground softens sufficiently to dig them. They are much improved by being left in the ground over winter. I often laugh to think of the way we used to plant flowers in our yard at home and nobody ever thought that the poor things needed a little fertile soil and cultivating.

"Well, the clock has pretty nearly turned the corner around, as the Dutchman says, so I will send the family's love to all and bring this ramble to an end. I was sorry you didn't let me know where you were stopping in Chicago, as I had planned to drop in on you. Please remember me to the boys and my more exalted friends at home. With best love to all.

"Affectionately,

"Fitz."

BOOK REVIEWS

Anatomy and Physiology of the Eye and Its Appendages. By John W. Croskey, M.D., Ophthalmic Surgeon to the Philadelphia General Hospital, Philadelphia, Pa. Philadelphia: Smith-Edwards Company. 1914. Illustrated.

This little pamphlet is devoted to the anatomy and physiology of the eye and is based upon a course of lectures delivered to students and nurses at the Philadelphia General Hospital. Though brief, it is accurate in statement and should render the acquisition of an intelligent idea of the anatomy and physiology of the eye easy. It is naturally too condensed to be used independently of textbooks, but for elementary studies should prove generally useful.

Some Important Memoranda for Busy Physicians. New York: Fellows Company.

This little booklet contains much recent information advantageous to the physician. It is neatly gotten up, and will be sent gratis to any doctor desiring it. It contains besides information on twilight sleep, short and succinct accounts of Osler's spots, the Cammidge urine reaction, Weiler's benzidin reaction for blood, Ehrlich's diazo reaction, Von Pirquet's cutaneous tuberculin reaction, Boston's sign in exophthalmic goitre, Kernig's sign in meningitis, Babinski's Achilles tendon reflex, Noguchi's Luetin skin test, Abderhalden's defensive ferment tests, etc. Verily, it is an excellent example of multum in parvo.

THE HOSPITAL BULLETIN

[illegible]

[illegible]

A change of diet is not only pleasant, but is [illegible] Wagner has sometimes a delightful and nutritious regimen at home, but we frequently become tired of a constant diet and long for a change. In the same manner a change in intellectual pabulum is also both pleasant and beneficial to the medical student as well as to the practitioner. There is doubtless advantage in the custom, more prevalent in other countries than in this, of attending courses in several universities. Our students, however, are to a very large extent content to remain with us during the whole of their undergraduate work, but it is good for them to have an opportunity to see and hear prominent teachers and investigators from other institutions. For a number of years we have been able to have special lectures given by subjects by distinguished members of the profession, amongst whom have been Dr. Charles H. Mayo of Minnesota, Dr. Wm. L. Jackson of Philadelphia, Dr. Richard Cabot of Boston and [illegible] Dr. Will S. Sadler of Chicago. During the present session we have been favored with [illegible] lectures on the physiology and pathology of the stomach by Dr. Lewis Gregory Cole of Columbia University, illustrated by numerous [illegible] demonstrations of the actual conditions described. The method is [illegible] and doubtless [illegible] stomach contents is practically of no value, and that to obtain information of diagnostic value it is necessary to make fractional examinations; that is a number of examinations during the whole period of digestion. As these methods do not require elaborate apparatus and only the expenditure of time and effort they are of great applicability and of great utility.

In the course on tropical medicine, Professor Ashford, himself an expert on tropical diseases, has brought to the University many distinguished lecturers on such conditions as cholera, yellow fever, bubonic plague, hookworm disease and dengue. Recently we were favored with a splendid lecture on the development of the malarial plasmodium both *in vivo* and *in vitro* by Professor [illegible] of Tulane University, New Orleans. He showed that these organisms would cause a blockage of the capillaries with a stasis of the circulation, and that quinine was unable to reach them until they had completed their cycle and had [illegible] and passed on. The cause of malarial fevers was thought to be due to a blocking of the cerebral capillaries, causing anemia of the brain. The practical lesson taught was that quinine should be given in large doses and continued for several days in order to kill the young plasmodia as they successively escaped from the blocked capillaries.

All these lectures have been largely attended by physicians as well as students.

THE PATHOLOGICAL ENDOWMENT FUND

This fund, like the fabled tortoise, does not make rapid progress in the race; nevertheless, some progress is being made, and we hope that it may eventually reach the goal. This goal is $100,000. There is now in hand $21,000.92, and considerable additional subscriptions have not been paid as yet. It would help us very materially if those who have kindly subscribed to the fund could send us checks for the amounts subscribed. [illegible] subscriptions received during March:

[illegible]

Frank C. Mixer, [illegible] $
Fred Rankin, [illegible]
Dr. W. [illegible]

[illegible] 37

ITEMS

DR. THOMAS FELL WILL REMAIN PROVOST OF THE UNIVERSITY OF MARYLAND AND PRESIDENT OF ST. JOHN'S COLLEGE.

Dr. Vernon L. Oler, class of 1911, writes us that at present he is with the Wolverine Copper Mining Co., Kearsage, Mich. He was formerly at the Polyclinic Hospital, 341-351 W. 50th street, New York city.

Dr. Charles E. Terry, class of 1903, is located at 2901 St. John's avenue, Jacksonville, Fla.

Dr. Challice Haydon Metcalf, class of 1914, has located at Lutherville, Md.

Dr. Oscar L. Rogers, class of 1897, is junior surgeon at the Rawlings Sanitarium, Sandersville, Ga. In a recent letter from him he sent his best wishes to "all around the old University."

Miss Lucy Scaggs, of the intermediate class, who was operated on at the hospital the last of February, is getting along nicely.

Miss Lillie Hull, of the intermediate class, who was operated on at the hospital recently, has gone to her home to recuperate.

Dr. James A. Nydegger of the United States Public Health Service returned to Baltimore March 29 from a trip to Florida, where he was sent by the Government to adjust a dispute between the local physicians of Manatee county and the State Board of Health regarding an affection of the eyes, from which a number of persons were suffering. Dr. Nydegger decided that the affection was trachoma. He also spent some time making a survey of the schools of Manatee county and made a number of addresses on school hygiene.

Eta Chapter of the Phi Sigma Kappa Fraternity entertained the graduate members at a smoker at the chapter-house on Saturday night, March 13. Many of the graduate members were present, and an enjoyable time was had talking over old times and plans for the future.

A theater benefit was held at Ford's on Wednesday night, March 17. The play presented was "The Bird of Paradise." The acting and scenery were fine, and the play was No. A1. The proceeds will go toward a new fraternity building.

The following were recent visitors to the University Hospital: Charles L. Schmidt, 1911, and Thomas H. Legg, 1907, of Union Bridge, Md.; Robert L. Abell, 1912, formerly one of the assistant physicians at the Hospital; Clifton N. DeVilbiss, 1910, of Laytonville, Md., and John W. Ebert, 1912, of Lutherville, Md.

The committee on sanitation of the Confederated Civic Association of Baltimore county met and organized March 19 at the Hotel Junker. Dr. J. Carroll Monmonier, class of 1897, of Catonsville, was elected chairman. Dr. Albert L. Wilkinson, class of 1903, of Raspeburg, was elected chairman of the public instruction committee, and Dr. Fred V. Beitler, B. M. C., class of 1906, of Halethorpe, chairman of the sewerage and water supply committee. A general discussion of sanitation followed the organization.

Dr. and Mrs. Page Edmunds, who sailed recently from New York on the Bermudian of the Quebec Line for the Bermudas, where they spent a few weeks, have returned to their home.

Miss Grace Tull, class of 1909, is doing substitute nursing in the infant milk work.

Miss Grace Stoneham, class of 1914, is spending a few days in the city.

Dr. John C. Stansbury, class of 1913, is doing special work in dermatology in the University Hospital dispensary. Dr. Stansbury has just recently returned from Glascow, Scotland. On the return trip he acted as ship surgeon. He resides at 1307 Edmondson avenue.

We are glad to have with us again two of our professors who have been quite sick. They are Dr. T. Casper Gilchrist, professor of dermatology, who has been ill with influenza, and Dr. Edgar R. Strobel, associate professor of dermatology, who has been suffering from an attack of the grip.

Dr. Howard Elmer Ashbury, class of 1903, announces the removal of his offices and X-ray laboratory to 827 N. Charles street, where the newest equipment has been installed for fluoroscopy diagnosis and X-ray therapy. Office hours, by appointment. Telephones, Mt. Vernon 2571 and [illegible].

Dr. Marshall Langton [illegible] of 1882, formerly of 6 E. Franklin street, has written to the Baltimore *Sun* stating that he is being held a prisoner in Lusahin. Dr. Pitcher was formerly secretary of the State Board of Health of Maryland.

Dr. John R. Lowery, class of 1904, who has been located at Cooleemee, N. C., has moved to Charlotte, N. C.

The Splint Club, composed of members of the medical faculty of the University of Maryland, held its annual dinner Thursday evening, March 18, at the Rennert Hotel. There were about 20 members present, and the dining-room rang with songs and cheers. Dr. J. Dawson Reeder, president of the club, presided and acted as toastmaster.

The club was formerly a secret organization, but now is open to anyone who wants to join, provided a few formalities are gone through. Dr. Hugh H. Young, B. Warfield was guest of honor of the club, and made an address. Others about the table also spoke. Those present were: [illegible] Dr. Gardner Wilson, John R. Abercrombie, Arthur M. Shipley, Frederick Rankin, G. Carroll Ireland, C. W. McElhosh, C. R. Wilkinson, Henry Fitzhugh, Edward E. Gibbons, Hugh Young, J. P. O'Neill, Compton Reilly, Frank Firor, [illegible] Carty, Robert L. Mitchell, J. W. Holland and Howard E. Ashbury.

The March meeting of the Obstetrical Society of Maryland was held in Chemical Hall, southwest corner Lombard and Eutaw streets, Tuesday, March 16, 8:30 P. M. The meeting was most interesting and instructive. Dr. Martin G. Mahon of Philadelphia gave an illustrated lecture on "Conclusions to Be Drawn from Recent Gastro-Intestinal Studies," followed by a discussion by Drs. Randolph Winslow and Frank J. Kirby. In addition there was a lecture on "Achylia" by Dr. Thomas R. Brown, followed by a discussion opened by Dr. Gordon Wilson. These monthly lectures are very instructive, and are well attended by the physicians and medical students.

In recognition of his long and faithful service at the Baltimore Eye, Ear and Throat Hospital, Dr. Jacob D. Hartman, class of 1860, of 8 E. Franklin street, one of the two living founders of the institution, was tendered a banquet Thursday evening, March 18, at the Rennert Hotel. A handsome silver service was presented the guest of honor by the staff of the hospital.

The banquet was attended by about 20 physicians and surgeons. Dr. Samuel Theobald, class of 1867, presided at the table, and at his left sat Dr. Hartman. At the close of the dinner the various members of the hospital staff were called upon and paid glowing compliments to Dr. Hartman, the tribute from Dr. Theobald, the other living founder of the hospital, being especially warm.

The seventh Pan-American Congress will meet in San Francisco June 17-21, inclusive. It assumbles pursuant to invitation of the President of the United States, issued in accordance with an act of Congress approved March 3, 1915.

Dr. Herbert Harlan, class of 1870, of 1301 Cathedral street, accompanied by his daughter, will leave for California early in May to visit the Panama-Pacific International Exposition at San Francisco.

Miss Jane Pennewell, a member of the Junior class, who was operated on recently for appendicitis at the hospital, is convalescing at her home in Snow Hill, Md.

Dr. Adolphus Lange Little, class of [illegible], is located at Williamsville, S. C. We are glad to know that he is doing so well. He was married several years ago, and has two fine boys.

Dr. Ralph Leland Lucas, class of 1911, is located in Davisboro, Ga. He was married on the 24th of December last.

It is exceedingly gratifying to us to learn that Dr. Leonce J. Kosminsky, class of 1906, is succeeding so well, as will be seen from the following letter. We extend our hearty congratulations to Dr. Kosminsky:

"Texarkana, Ark., March 29, 1915.

"Dr. N. Winslow, Baltimore, Md.:

"Dear Doctor—Enclosed find check for $3 in payment of HOSPITAL BULLETIN to April, 1916. Glad to say I am getting along nicely. They are treating me very nicely in my home town. Was elected Exalted Ruler of the Texarkana Lodge of Elks, No. 399, and promoted from local surgeon for the Missouri Pacific Railway Co. to assistant and examining surgeon. Glad my qualifications given me by the University of Maryland education have proven so satisfactory.

"Notice from BULLETIN that you are now doing surgery only. Permit me to wish you great success.

"Remember me kindly to the Faculty. With best wishes to you and yours, I am, as ever,

"Your friend,

"L. J. KOSMINSKY, 1906."

Dr. Robert Lawson Kennedy, class of 1910, is located at Havana, Fla., where he has been for the past three years. Prior to locating in Havana Dr. Kennedy was resident physician at the Florida Hospital for the Insane. He also practiced in Citra, South Florida, for four months, where he contracted typhoid fever, from which it took him a year to recuperate. It is a pleasure for us to know that Dr. Kennedy has succeeded in building up a good practice, and we extend to him our congratulations.

The annual meeting of the Nurses' Alumnae Association of the University of Maryland was held at the University Hospital on April 5. Miss C. A. Cox, class of 1908, was appointed delegate to the convention of the American Nurses' Association, to be held in San Francisco, Cal., from the 20th to the 26th of June.

The following officers were elected for the ensuing year:

President—Miss M. E. Rolph, class of 1895.

First Vice-President—Miss Mary Gavin, class of 1908.

Second Vice-President—Mrs. Page Edmunds, class of 1905.

Secretary—Mrs. Frank S. Lynn, class of 1908.

Treasurer—Mrs. Nathan Winslow, class of 1903.

Members of the Executive Committee—Misses Nancy MacNabb, class of 1907; C. A. Cox and S. A. Hostrawser, both of the class of 1908, and M. E. Sullivan, class of 1911.

Dr. Ernest L. Griffith, class of 1907, has moved from Huntington, W. Va., to Clifton Forge, Va.

Dr. Walter H. Mayhew, class of 1901, is at Trudeau, N. Y. He was formerly at the State Sanatorium, Sabillasville, Md.

We note in the March issue of the Hospital News of the Georgetown University Hospital an article, entitled, "The Critical Periods of a Woman's Life," by Dr. Henry D. Fry. Dr. Fry is a member of the class of 1876, and resides at 1929 19th street N. W., Washington, D. C. He is professor of obstetrics and clinical professor of gynecology in the Georgetown University School of Medicine.

We are in receipt of the two following newsy letters from Dr. Robert Lawson Kennedy, class of 1910, who is located at Havana, Fla.:

"Havana, Fla., March 15, 1915.

"Dear Dr. Winslow:

"I received a letter from my old friend Dr. Michel Samaan Hanna, who is back at his old home in Tanta, Egypt, and from his letter he has done exceedingly well. I know he has, for he is thoroughly reliable. I roomed with him my senior year while I was clinical assistant at the University Hospital.

"I have been located here for the past three years, and have gotten along nicely, considering there are four other physicians in this town, and they all have been located here for a long time. They have been fighting me ever since I have been here, but I have just kept quiet and attended to my own business and let them do the talking. I have an Overland roadster, and do my city and country work in it. I wrote to the HOSPITAL BULLETIN some time ago and asked that you tell of my being located in Havana, Fla., but you must have overlooked it or in the rush of your other duties you didn't think of it. Kindly put in your next issue of the BULLETIN that Dr. Robt. L. Kennedy, class of 1910, is located at Havana, Fla., and has been for the past three years. Before this, I

[illegible] Gadsden Medical Society on the 2d, and we had a good meeting. Drs. Palmer, Moore, Johnson, Quinn and Brevard are all graduates of our school. They are located at Dillon, S. C., and Dr. C. C. Mack at Quincy. We have a good society. I had them meet here last July, the first time they had ever met in this town. In February we met at the insane asylum and had Dr. Raymond C. Turck of Jacksonville give us a clinic in orthopedic surgery. I liked him. There is much resemblance between him and Dr. Eadon. At the meeting held with me last July I read a paper on burns, and their etiology, pathology and treatment, and Dr. Davis of Quincy read a paper on traits and taints. Please publish this and tell my classmates to write to me, for I would be glad to hear from them.

[illegible]

Havana, Fla., March 11, 1911.

Hospital Bulletin Co., Baltimore, Md.

Gentlemen—I am today in receipt of your March HOSPITAL BULLETIN, and enjoyed it very much. I sent you a letter Monday, enclosing one from my old roommate, 1909-1910, at the University Hospital, Michel Samaan Hanna, M.D., Tanta, Egypt. Hanna is a fine man. I want you to be sure to put what I asked you to in your April BULLETIN, as it will reach my friends, and maybe some of them will write to me, for I would be glad to hear from them. I wish you would mention that Adolphus Loma Little, 1910, is located at Wilkinsville, S. C., and has two fine boys; also that Dr. Ralph Leland Taylor, 1911, is located in Darlington, La. He was married December 24, and is doing very well. Hoping to see this and what I wrote you in my other letter in the [illegible] I am,

"Your former pupil,

[illegible]

We are in receipt of the following interesting letter from Dr. Michel Samaan Hanna, class of 1910, of Tanta, Egypt:

[illegible]

"Dear Dr. Nathan:

"I am getting the BULLETIN monthly on time, and to me it is a great joy to see it. It makes me remember [illegible] and touch the University again, and I [illegible] to see the pictures of the [illegible] of the different Alumni. I was [illegible]

over and miss no paragraph, but I must say that I read over twice or three times anything about the 1910 class. I owe you one year's subscription, and am going to send it as a money order right now if the new laws of the postoffice admit that at present, if not, I will postpone it to another occasion.

"I have performed a complete abdominal hysterectomy for fibromata of uterus under such difficult conditions, poor assistance, and with such a splendid and speedy recovery.

"Yesterday I received a letter from R. L. Kennedy. He is located in Havana, Fla., and is doing well.

"We are in a state of war, and will very soon have to fight at the eastern borders. The English have fortified the canal with all means of recent defense, and we do not believe any power under the sun will ever be able to invade Egypt through the canal.

"I am doing very well here, and have done in surgery operations the result of which I am very proud, such as hysterectomies, hernia, thyroidectomies, pyonephrotomies, cystostomies, etc., and one appendectomy. Kindly give my best compliments and respect to Professors Winslow, Coale and Shipley, and to Drs. Coleman, Robert Bay and Mr. Johnson. With best compliments to you, I remain,

"Very sincerely yours,

"M. S. Hanna."

"P. S.—You may get this letter directly from Egypt, or perhaps from Florida, for I may send it with the mail I am sending to my friend, Dr. R. L. Kennedy in Havana, Fla."

Dr. G. B. Morris, class of 1910, is located at Mt. Olive, N. C.

Dr. H. Graham Stoneham, class of 1913, is located at Waverly, Va., where he is practicing his profession.

We are glad to learn that Dr. Walter L. Richards, class of 1914, who was recently operated on at the University Hospital, is doing nicely. We wish him a speedy recovery.

Dr. Eugene F. Raphel, class of 1906, who has been located at 125 Orchard street, Keyser, W. Va., has moved to Cumberland, Md. Dr. Raphel is not in practice.

Dr. Louie E. Langley, class of 1910, who has been located at 436 Market street, Williamsport, Pa., has moved to 3 W. 3d street.

BIRTHS

To Dr. James Herbert Bates, class of 1907, and Mrs. Bates, of Millington, Md., February 28, 1915, a daughter—Margaret.

Recently to Dr. J. Dawson Reeder, class of 1901, and Mrs. Reeder, of 639 Fulton avenue, Baltimore, a daughter.

DEATHS

Thomas Gay Whims, class of 1911, of Lasker, N. C., died at the University Hospital March 7, 1915, after a lingering illness, aged 38 years.

Dr. Henry Walton Wood, class of 1902, of 446 County street, New Bedford, Mass., died in February, 1915, at the Jefferson Hospital in Philadelphia, after a lingering illness. He had been sick about 18 months.

Dr. John H. Jenness, class of 1887, of Rising Sun, Md., died at his home March 29, 1915, aged 52 years.

Dr. Jenness attended school at West Nottingham Academy, and afterward graduated from St. John's College, Annapolis, and later from the University of Maryland.

He was a close friend of the late Governor Austin L. Crothers, and when a young man served as assistant teacher with the Governor in the public school at Oakwood. He was a member of the Maryland Legislature in 1898, and was appointed by Governor Warfield school commissioner for Cecil county, a position he held at his death. He is survived by his widow and son, Richard H. Jenness.

Mary Virginia Dowdell, R. N., University Hospital Training School for Nurses, class of 1906, of Baltimore, Md., died after a short illness in Baltimore March 22, 1915.

Dr. Samuel Claggett Chew, [illegible] 1858, was [illegible] of the Medical and Chirurgical Faculty of Maryland, and the only man who was [illegible] with that title. [illegible] of Baltimore physicians, member of the Board of [illegible] of the University of Maryland for [illegible] forty years, and one of the most eminent as well [illegible] of the best-loved physicians of Maryland, died at his home, 3 Midvale road, Roland Park, of heart trouble, after a long illness, March 22, 1915, [illegible] years.

Dr. Chew was eminent as a physician and [illegible] in Maryland for many years. He had been [illegible] in the practice of medicine in Baltimore [illegible] 1858, and he was a member of the [illegible] of the School of Medicine of the University of Maryland from 1864 to 1909. In this latter year he resigned, not because he was no longer able to lecture, but because he said that at 70 he thought himself entitled to a rest. It was not until his last illness set in that he was compelled to [illegible] activities in various fields entirely.

The name of Chew has been illustrious in medicine in Maryland for nearly a century. Dr. Chew's father, Samuel Chew, was a distinguished physician of his day, and preceded his son on the faculty of the University of Maryland School of Medicine. The connection of the father and son with the University extended over the greater part of its history.

The elder Chew was a native of Calvert county, where he was born in the same house in which his people had lived since early Colonial times.

Samuel Claggett Chew was born in Baltimore on July 26, 1837. He was given his bachelorship of arts at Princeton University in 1856. Two years later he was made a doctor of medicine by the University of Maryland, which school also made him a doctor of laws in 1907.

[illegible] THE UNIVERSITY.

Dr. Chew was professor of materia medica at the University of Maryland from 1864 to 1885, [illegible] practice of medicine. He was dean of the faculty from 1874 to 1879, and president of the [illegible] association in 1878. [illegible] 1872 and 1873 he was secretary of the Medical and Chirurgical faculty of Maryland. He was president in 1880, and again in 1898, the only man ever to have been honored in this [illegible].

When the Pinkerton [illegible] Institute [illegible] the University of Maryland, in June, 1908, he was made emeritus professor in recognition of his faithful services to the institution. The resolution of regret and respect which the faculty passed when his resignation was received recited the fact that he had been connected with the University of Maryland for 45 years, recounted his many deeds of kindness and charity and recalled his great learning that he used in the advancement of medical science and the alleviation of human suffering.

In his long service with the University of Maryland Dr. Chew taught some of the men who have since become leading physicians in this and other cities, and it has been said that a majority of the present practitioners in Maryland listened to his lectures.

As a lecturer Dr. Chew was regarded as clear, concise and explicit, and as a demonstrator most convincing and elucidating. And, as with his lectures and demonstrations, so with his various professional essays and addresses.

During all these years Dr. Chew had also his private practice, as well as his duties at the University of Maryland. His recognized professional skill brought him a large number of patients. When he resigned his professorship he remarked that his private practice consumed much of his time, and that to give it proper attention meant much stress and strain.

But it was not only in his profession that Dr. Chew attained eminence. He also attained a high place as a scholar and man of letters. He was always a student and a lover of good literature. As a trustee of the Peabody Institute, of which body he was for many years president, and as a lecturer on many subjects, he served to promote the advancement of learning.

On November 20 of last year the Baltimore City Medical Society presented the Medical and Chirurgical Faculty with a portrait of Dr. Chew, from the brush of Miss Marie Deford Keller, which was painted in Dr. Chew's library at his home in Roland Park. Most of the representative physicians of Baltimore were present on the occasion, but Dr. Chew himself felt his health would not permit him to go out at night, so he was not present to hear the glowing tributes paid to him as physician, teacher and man.

His death has saddled a shard of mingled grief and pathos in the memory of hundreds of his fellow-men throughout the State of Maryland.

Dr. Chew married Agnes B. Marshall of Baltimore in June, 1884.

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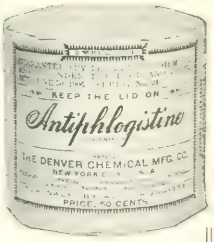

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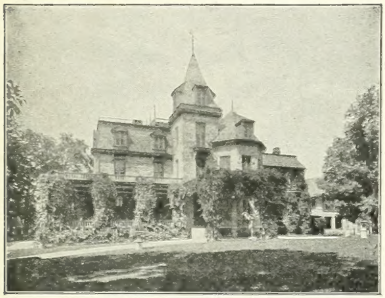

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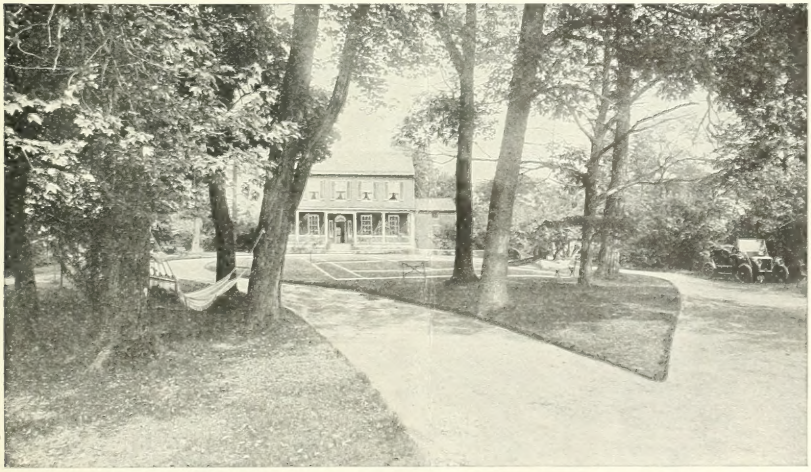

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